

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032583

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

8507

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN ST. LOUIS, MISSOURILength of stay in 1b
27 DAYSc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION VAH, 915 N. GRAND AVE.Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MISSOURI b. COUNTY

c. CITY
OR
TOWN ST. LOUISInside Limits
Yes ☒ No ☐d. STREET
ADDRESS 4011 DELMAR BLVD.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

WILLIAM JONES JR.

4. DATE
OF
DEATH

Month

Day

Year

8/31/62

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

5/26/14

9. AGE (last birthday)

18

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

BLYTHALL, ARKANSAS

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

WILLIAM JONES, SR.

13b. MOTHER'S MAIDEN NAME

MARGARET LASSETER

14. NAME OF HUSBAND OR WIFE

MARY JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

YES

WW-II

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MARY JONES (WIDOW) SEE #2

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Convulsive Disorder

INTERVAL BETWEEN
ONSET AND DEATH

14 Mos

DUE TO (b)

Post Operative Craniotomy

14 Mos

DUE TO (c)

Astrocytoma Grade III

1930

1-2 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☐☐☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. Attended the deceased from
Death occurred at 11:00 A.M.

8/4/62

to 8/31/62

and last saw him alive on 8/31/62

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

9-6-62

23c. LOCATION (City, town, or county)
(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE REC'D. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Richardson

2625 Glasgow

SEP 4 1962

Gordon W. P. M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1

2 2/9

3

4 2

5 1

6

7 1

8 2

9

10

11

12 83-0

13

83

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. Richardson

Licensed Embalmer No. 2928

P. O. Address City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.